Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS666HOS	A. BUILDING _____ B. WING _____	08/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
U M C OF SOUTHERN NEVADA	1800 WEST CHARLESTON BLVD LAS VEGAS, NV 89102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation,s actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted at your facility on 8/1/08. The following complaints were investigated: CPT # NV18870- substantiated. (See Tag: S 310) The following regulatory deficiencies were identified:	S 000		
S 310	NAC 449.3624 Assessment of Patient 1. To provide a patient with the appropriate care at the time that the care is needed, the needs of the patient must be assessed continually by qualified hospital personnel throughout the patient's contact with the hospital. The assessment must be comprehensive and accurate as related to the condition of the patient. This Regulation is not met as evidenced by: Based on record review, the facility failed to provide the patient with the treatment to the wounds assess by the nurse at the time of admission to the hospital . Findings include: Patient #1 Patient #1 was seen in the emergency room and	S 310		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 310	Continued From page 1 admitted on 2/10/08 and discharged on 3/4/08. The patient's past medical history included Diabetes Mellitus, Myocardial Infraction; Cerebrovascular Accident, Adenocarcinoma of the Uterine and Cervix, Hypertension, Hypothyroidism and Remote History of Anemia. On 2/10/0,8 the patient was seen in the emergency room with abdominal pain and nausea and vomiting last night and today. The patient had a diagnosis of adenocarcinoma of the uterine and cervix. The patient was unable to keep down food. The Adult Admission Assessment form, dated 2/11/08 at 0040 (12:40am), the skilled nurse identified blisters located on the right and left great toes. There was no documented evidence to verify the skilled nurse notified the physician about the the blisters located on the right and left toes at the time of admission. There was no further documentation by the professional nursing staff the blisters on the right and left toes were assessed during the patient's hospital stay. Severity: 2 Scope: 1 CPT # NV18870	S 310		